U.S. Public Health Service Commissioned Corps Readiness Force Student Application

Please initial next to each line on the form below confirming that you have met the OFRD course prerequisites. Fax this page along with your completed course application and a copy (front and back) of your BLS for Healthcare Providers card to the OFRD fax number on the following page.

INITIAL	APPLICATION PREREQUISITES						
	Supervisor's permission to attend.						
	Own at least 2 complete pairs of the working khakis.						
	Completed physical exam on file with MAB within past 5 years.						
	Certified in AHA BLS for Healthcare Providers and recorded on OFRD Officer Summary Page. You must fax a copy of your BLS card (front and back) with your application.						
	Current licensure (if applicable) on file with OCCO and recorded on OFRD Officer Summary Page.						
	Immunization requirements to meet Basic readiness completed and recorded on OFRD Officer Summary Page.						
	Current APFT recorded on the OFRD Officer Summary Page or completion of award level of President's Challenge program.						
	Recorded height and weight on OFRD Officer Summary Page.						
	Recorded the number of hours you practice as a Mental Health provider on OFRD Officer Summary Page.						
	Current login and update of OFRD Officer Summary Page.						
	Completion of prerequisite online sessions specified in the course course description.						



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1101 Wootton Parkway Suite 100 Rockville, MD 20852 Fax (240) 453-6110



Course Title:						Course Date:				
Montal Haalth Disactor Pospones Training						Select only ONE course date ☐ July 25-29, 2005				
Mental Health Disaster Response Training □ July 25-29, 2005										
PHS Serial Number		# Clinical Hours			BLS for Healthcare Provider					
PHS Serial Number S.S.N. (SERNO)				Within the past 12 months			Expiration Date			
Name (LAST) (FIR) Rank			PHS Category:				
(2.10.1)	(1.1101)	(11101)								
Home Address:	City, State, Zip Code:									
Home E-Mail:	Home Phone:				Mobile/Pager:					
Duty Station Address:				City, State, Zip Code:						
			,	,						
							1			
Work E-Mail:				Work Phone:			Work Fax:			
OPDIV/Agency:				Current Job Title:						
Mode of Transportation: check	k applicable	If traveling by a	ir plea	ase specify Airpo	orts of Depa	rture [.]				
☐ Automobile ☐ Air Travel ☐ 1st Choice			2 nd Choice							
		•				0110100	,			
Why should you be selected for this course? Indicate what field experience you have had?										
Supervisor's Name			Cuna	ervisor's Signatui	ro			Date		
Oupervisor s Marrie			Supe	n visur s Signatui	I C			Dale		